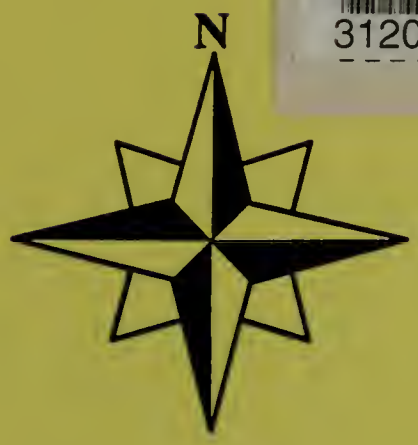

A Massachusetts Guide to Health Insurance CHOICES

---Health Insurance Options for Medicare Beneficiaries and Senior Citizens

Commonwealth of Massachusetts
Executive Office of Elder Affairs

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Governor

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Acting Secretary

1998 Edition

Disclaimer

The Executive Office of Elder Affairs does not sell, recommend, promote, or endorse any insurance product, company or agent. The information in this guide is being provided to assist consumers in making informed purchasing decisions. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This guide will be updated periodically.

Credits

Each year, the Massachusetts Serving Health Information Needs of Elders (SHINE) Program provides education and assistance to thousands of our state's elders, Medicare beneficiaries, and their family members. SHINE's CHOICES Booklet was developed to address the many questions elders have in dealing with their health insurance options.

SHINE, a free and confidential counseling service, is funded by the Executive Office of Elder Affairs and through grants from the United States Health Care Financing Administration, the Massachusetts Councils on Aging Grant, and in-kind donations from hundreds of member agencies and program sponsors.

This consumer booklet was adapted from materials produced by the New York Health Insurance Information, Counseling, and Assistance Program (HICAP) for use in pre-retirement educational programs.

Please note this booklet applies only to the options available to residents of Massachusetts. There are 53 health insurance counseling programs throughout the United States and territories. There is a listing of all the health insurance counseling programs in the *Medicare Handbook*, which is available from the Social Security Administration.

To locate a SHINE counselor in your area, please refer to the SHINE Directory located at the end of this booklet.

A Massachusetts Guide To Health Insurance CHOICES -- Health Insurance Options For Medicare Beneficiaries And Senior Citizens

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INTRODUCTION

This Massachusetts-specific educational booklet was designed by the Executive Office of Elder Affairs' health insurance counseling program, Serving Health Insurance Needs of Elders (SHINE), to give you an overview of the health insurance choices available once you are eligible for Medicare. Like pieces of a puzzle, there are many types of health insurance alternatives that are designed to fill the "gaps" in Medicare coverage. Choosing too many pieces - too many different kinds of coverage - is wasteful and unnecessarily expensive.

Use this booklet to explore your choices and determine which combinations will add up to affordable, adequate coverage. Then, consider meeting with a trained and certified health insurance counselor of the SHINE Program to discuss any questions you may have. SHINE Counselors provide free, unbiased and confidential counseling to Medicare beneficiaries and senior citizens.

Health insurance costs are rising. Don't overlook any of the possibilities. You may find you can reduce some of your health care costs. It's your choice! SHINE Counselors can help you explore your health insurance options. So, call your regional SHINE Health Insurance Counseling Program today.

INSURANCE COVERAGE FOR MEDICARE BENEFICIARIES

MEDICARE

GROUP PLAN FOR ACTIVE EMPLOYEES

RETIREE PLANS **COBRA** **MEDICAID, QMB, SLMB**

MEDIGAP (MEDICARE SUPPLEMENT INSURANCE)

MEDICARE MANAGED CARE PLANS (HMO)

LONG-TERM CARE INSURANCE **OR** **OTHER HEALTH INSURANCE**

SHINE Counselors provide free and confidential face-to-face counseling on all of these topics. Call or meet with a SHINE Health Insurance Counselor to learn what your options are and how to use the benefits you have. The SHINE Program's telephone directory is printed at the end of this booklet.

Medicare

Medicare! I have complete health care coverage!"

Once you are retired and reach 65, you probably will have Medicare, a basic piece of health insurance. Medicare is the payer of health care costs for most older Americans and for some disabled Americans of any age. It is divided into two parts: Hospital Insurance (Part A) and optional Medical Insurance (Part B).

Do you need Medicare coverage?

Absolutely! Either at age 65, if you are retired, or later, if you or your spouse work and have a qualified Employer Group Health Plan (EGHP).

Who's eligible for Medicare?

You are eligible for Medicare if you or your spouse worked for at least 10 years, and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with chronic kidney disease. Most people receive Part A Hospital Insurance premium-free. And if you decide you want Part B Medical Insurance, the monthly premium is $43.80 for 1998.

MEDICARE GAPS: Deductibles, Coinsurance, Excess Charges, or Non-Covered Services & Supplies

But will Medicare be all you need?

Probably not. Medicare was not designed to pay 100% of your health care bills. Instead, it's a cost-sharing program in which you and Medicare share your health care costs. The chart on the next two pages shows how, Medicare Part A and Part B, will pay part of your hospital and medical costs. It shows your responsibility - deductibles, coinsurance and permissible excess charges. You are responsible to pay fully for health care that is not covered by Medicare -prescription drugs and dental care, for example.

So how do you cover yourself for these "gaps" in Medicare?

You can adequately supplement Medicare, in most cases, with just one of the choices described on the following pages. Choosing too many different kinds of health insurance may be a duplication in coverage and unnecessarily expensive.

Read more about Medicare:

The booklet, "Your Medicare Handbook" may be obtained by calling the Social Security Administration at 1-800-772-1213.

1998 MEDICARE "Gaps": Deductibles, Coinsurance and Non-Covered Services

PART A Hospital

Inpatient Hospital Deductible & Coinsurance

First 60 Days	$764.00 per benefit period*
Days 61-90	$191.00/Daily
Days 91-150	$382.00/Daily Lifetime Reserve Days

Skilled Nursing Facility Coinsurance

First 20 Days	$ 0.00
Days 21-100	$95.50/Daily

PART B Medical

Deductible	$100.00/Annually
Coinsurance	20% of Medicare's approved amount**

PREMIUMS

PART B Medical	$43.80/Monthly
PART A Hospital	None, most beneficiaries receive Part A premium free. If someone has to purchase Part A, the premium will be $170 or $309 monthly.

*A benefit period provides 90 days of hospital care, if needed. A new benefit period begins each time the beneficiary is out of the hospital or has not received skilled nursing care from any other facility for 60 consecutive days.

**Part B Coinsurance is paid after you have met the annual Part B deductible of $100 for covered services in 1998. A 20% coinsurance amount applies to most physician services. A 50% coinsurance applies to most out-patient mental health services.

Services not covered by Medicare: Private Duty Nursing, Experimental Procedures, Care Outside of the U.S., Custodial Care at Home, Custodial Care in Nursing Home, Most Prescription Drugs, Hearing Aids, Eyeglasses (generally), Most Chiropractic Services, Dental Care, Acupuncture, Routine Physicals, Private Hospital Room, Cosmetic Surgery, TV and phone in hospital.

1998 Medicare Part A Benefits and Gaps

(Chart outlines gaps in Medicare coverage. Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part A		
Inpatient Hospital Care*		
Days 1-60	$764 deductible	Balance
Days 61-90	$191 per day	Balance
Days 91-150 (*lifetime reserve days*)	$382 per day	Balance
All additional days	All costs	Nothing
Semiprivate room and board, general nursing, and other hospital services and supplies.		
Skilled Nursing Facility Care*		
Days 1-20	Nothing	All costs
Days 21-100	$95.50 per day	Balance
All additional days	All costs	Nothing
After three-day hospitalization and admitted to a skilled nursing facility approved by Medicare within 30 days of discharge.		
Home Health Care** Part-time or intermittent skilled care, home health aide services, and **Durable Medical Equipment and Supplies**	Nothing 20% of approved amount	Up to 35 hours per week 80% of approved amount
Hospice Care Pain relief, symptom management and support services for the terminally ill.	Small co-payments for inpatient respite and drugs	Balance
Blood	For first 3 pints	All but first 3 pints per calendar year

* Benefits listed are per benefit period which begins the first day you receive inpatient hospital care and ends when you have been out of a hospital or other facility providing skilled nursing or rehabilitation services for 60 days in a row.

** Medicare Part B will pay for home health services if you do not have Part A. Note: Medicare premiums, deductibles and co-payment amounts are subject to change annually.

Medicare Part B Benefits and Gaps

(Chart outlines gaps in Medicare coverage. Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part B		
Medical Expenses • Doctors' services • Inpatient and outpatient medical services and supplies • Physical and speech therapy • Diagnostic tests • Ambulance services Medicare also pays for other medically necessary services, see Medicare Handbook.	$100 deductible* plus 20% of Medicare's approved amount. Limited charges above the approved amount may apply for some Part B providers.	80% of Medicare's approved amount after $100 deductible has been met. Reduced to 50% for most outpatient mental health services.
Clinical Lab Tests Blood tests, urinalysis, and more.	Nothing for tests if medically necessary.	Generally 100% of approved amount.
Home Health Care** Part-time or intermittent skilled care, home health aide services, and Durable Medical Equipment and Supplies	Nothing 20% of approved amount	Up to 35 hours per week 80% of approved amount
Outpatient Hospital Treatment	After $100 deductible, 20% of the **hospital charges** (not limited to approved amount).	Medicare payment to hospital based on hospital cost.
Blood	For first 3 pints, plus 20% of approved amount (after $100 deductible).	80% of approved amount (after $100 deductible and starting with the 4th pint).

* Once you have incurred $100 of expenses for Medicare-covered services in any year, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** If you have both Medicare Part A and Part B, your Part A will pay for home health services.

ENROLLING IN MEDICARE

The Four Enrollment Periods: Automatic, Initial, Special, and General

"I'm retiring at 65. How do I enroll in Medicare?

When you retire at age 65, Medicare enrollment is fairly straightforward; you are either automatically enrolled or you need to apply. When you should apply will depend upon your person situation. The 4 periods are described below.

1. The Automatic Enrollment Period

If you are already receiving retirement benefits from Social Security or the Railroad Retirement Board when you turn 65, you should automatically get a Medicare Card in the mail about three months before your 65th birthday. This card lets you know that you have been enrolled in Medicare both Part A (Hospital) and Part B (Medical). If you do not want Part B coverage follow the instructions that come with the card. If you are under 65 and disabled, you will get a Medicare card in the mail after you have received disability benefits from Social Security (or the Railroad Retirement Board) for 24 consecutive months. Medicare coverage may begin sooner for individuals who have permanent kidney failure (End Stage Renal Disease) or need a kidney transplant.

Medicare Enrollment Periods For Those Who Do Not Receive Social Security Before Turning 65

If you are not receiving Social Security or Railroad Retirement benefits three months before you turn 65, you need to contact Social Security and apply for Medicare. To obtain the appropriate application forms for Medicare enrollment, contact any Social Security office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

When can I apply for Medicare?

You need to know you have 3 times in which you can sign up for Medicare - you can save a lot of money, or pay big penalties, depending upon when you sign up. There are 3 enrollment periods when you can sign up: the Initial Enrollment Period, the Special Enrollment Period and the General Enrollment Period.

2. *Initial Enrollment Period*

You can sign up for Medicare during the initial **seven-month** enrollment period starting **three months prior** to the month of your 65th birthday and ending **three months after** the month of your 65th birthday. It is wise to apply within the three months before you turn 65. By applying early, you'll avoid a possible delay in the start of your Part B coverage.

INITIAL Enrollment Period (**Parts A or B**)

Mo. 1	Mo. 2	Mo. 3	Mo. 4 Month of 65th Birthday	Mo. 5	Mo. 6	Mo. 7

-three months prior to the month of your 65th birthday
-the month of your 65th birthday
-three months after the month of your 65th birthday

3. *Special Enrollment Period*

"I'm retiring after age 65, when do I enroll in Medicare?"

One of the most important and potentially confusing issues for individuals who continue to work after age 65 is when to enroll in Medicare. Should you wait until you stop working, or enroll as soon as you turn 65?

Enrollment in Medicare Part A

Most people age 65 and over can get Medicare Part A (Hospital) **premium-free** based on their own or their spouse's Social Security record of employment. Therefore, it is to your advantage **to enroll in Part A at age 65** even if you continue to work and are covered by an employer's group health plan.

While your employer's plan will be primary (pay first), you will then be assured of Medicare Part A benefits if they are needed. For example, if your health plan does not pay all of the cost of a hospital stay, Medicare Part A may pay all or part of the balance.

You can enroll in Medicare Part A three months before reaching age 65, or at **anytime thereafter**. Simply contact Social Security and file a special application. If you are eligible for Part A premium-free, there is no penalty for late enrollment.

Enrollment in Medicare Part B During the Special Enrollment Period

If you are covered by a group health plan based on your own or your spouse's **current employment** (not a plan for retired people and their spouses), you can delay enrollment in Medicare Part B (Medical) insurance without penalty. You can then enroll at retirement or termination of the employer's health plan during a **special enrollment period.**

The **eight-month** Special Enrollment Period for Medicare Part B begins the day that you (or your spouse if your coverage is based on your spouse's current employment) are no longer actively employed **OR** your coverage under the group health plan ends, **whichever comes first.** Note, the group health plan must be based on current employment. It cannot be a plan for retirees.

SPECIAL Enrollment Period (Parts A or B)

Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8
Month of Termination of Employer's Health Plan							

4. General Enrollment Period

"I'm turning 70 and do not qualify for the special enrollment period. When can I enroll in Medicare?"

The **General Enrollment Period** is for late enrollees - those who did not enroll during the **Initial** (at age 65) or **Special** (if applicable) Enrollment Periods.

The General Enrollment Period takes place during **January, February, and March** of each year. Coverage under Medicare Part B will begin July 1st of that year.

"Is there a penalty for late enrollment?"

Yes! If you are a late enrollee and sign up for Medicare Part B during the general enrollment period, you will have to pay a permanent surcharge of 10% of the current premium for each 12 month period of late enrollment.

For example, if you enroll in Part B at age 70, 5 years after turning 65, the surcharge will be 50% (5 years x 10%) of the current Part B premium. In 1998, this would mean the late enrollee would have to pay $65.70 per month for Part B, instead of $43.80 per month. This financial penalty would be added on to the monthly Part B premium for the rest of your life.

"Is there any way to avoid paying this penalty? "

Yes. You may delay enrolling in Part B without penalty if you were enrolled in a group health plan based on your continuous and current employment. This waiver of penalty also applies if you are covered under a working spouse's plan. You would need to enroll in Medicare during the **special eight-month enrollment period** (detailed on page 7). Other exceptions may apply particularly for disabled beneficiaries.

For more information about Medicare enrollment rules, contact Social Security at 1-800-772-1213.

GENERAL Enrollment Period (for late enrollees)

JAN	FEB	MAR	APR	MA	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Open	Enroll	ment				July 1st Coverage Begins					

Health Insurance Choices For Medicare Beneficiaries And Senior Citizens

1. EMPLOYER GROUP HEALTH PLANS

"I'm over 64, but still working! What are my options?"
You may be able to obtain health insurance coverage through your current employer. If you continue to work for an employer who has 20 or more employees, the employer is required, by law, to offer you and your spouse the same choice of health care plans offered to employees under age 65.

Do I need to enroll in Medicare Part B while I'm still working?
No, you may delay enrolling in Part B without penalty if the group health plan is based on your continuous and current employment. This waiver of penalty also applies if you are covered under a working spouse's plan.

Choices?
Some companies offer their employees only one health insurance option. Or, your employer may ask you to choose one of several plans you would like for the coming year. For example, the choice may be between a fee-for-service health insurance plan (indemnity) or a managed care plan such as an HMO or Preferred Provider Organization (PPO). Be aware the HMO plan offered by your employer will not have the same benefits as a Medicare-contracted HMO plan because it is a different contract for care.

Benefits?
The employer plans available to you might be more comprehensive and less costly than what you can get in a Medigap (non-group) policy or Medicare HMO. Since employment-related plans are individualized for each company or organization, there are literally thousands of them in force, with no two alike in benefits and costs.

Use the checklist and comparison charts on page 12 and 19 to illustrate for yourself the benefits and limitations of your health plan. If you do not have a current copy of your plan's benefit booklet, contact your employer's human resource department or employee benefits coordinator.

If I decide to continue with my employer health plan and enroll in Medicare Part A only, who pays first?
If you are actively working, the employer plan will pay first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary for Part A covered services such as hospitalization, skilled nursing facility care, home health and hospice care.

2. EMPLOYER SPONSORED RETIREE PLANS

"What are my options if I have a retiree plan and Medicare?"
Roughly 1/3 of retired Americans have this piece of the health care puzzle - a health insurance plan from their former employer. When you become eligible for and enroll in Medicare, your retiree plan will be the secondary payer after Medicare. You'll use this retiree plan to supplement Medicare, to pay some of the costs Medicare does not pay.

Value?
Your retiree plan might be more comprehensive, less costly, or both, than the coverage most elders can get in a Medigap policy or Medicare HMO plan.

Benefits?
Your retiree plan is **not** a Medigap policy, but it may pay like one. Or it may pay more - providing additional benefits, for example. Retiree plans are all unique. Contact your employee benefits representative for a benefits booklet and learn:

- your benefits; if and how they fill (or don't fill) Medicare gaps
- your lifetime maximum benefit
- your (or your spouse's) ability to continue coverage if the retiree dies

Choices?
Each year your former employer may ask you to choose which of several plans you would like for the coming year. For example, the choice may be between a fee-for-service health insurance plan (indemnity) or an HMO. Be aware the HMO plan offered as a retirement benefit may or may not offer the same benefits as a Medicare-contracting HMO plan.

"What if my retiree plan ends, becomes too expensive, or has no worthwhile benefits?"
Many employers are changing retiree health plan benefits - either increasing your share of the premiums, cutting benefits, increasing deductibles, or all of the above. Some have dropped retiree health coverage entirely.

Alternatives?
Enrolling in a Medigap policy or Medicare HMO plan are two options you may want to consider. If your income is low, you may qualify for Medicaid or a Medicare Buy-In Program (QMB & SLMB). In some cases, these alternatives might provide better or more appropriate benefits, be more cost-effective, or coordinate with Medicare more to your advantage. See page 27 to learn more about Medicare Buy-In and Medicaid Program rules.

Employer Health Insurance Plan Review

SOME THINGS TO CONSIDER ABOUT YOUR EMPLOYMENT RELATED BENEFIT PLAN

Does the employer's plan continue after retirement? _____

Does the plan appear to be secure, or is the employer cutting back on benefits? _____

Does the plan cover the retired person's spouse or other dependents? _____

Will the spouse/dependent be covered if the retired person dies? _____

What are the lifetime maximums in the employer's plan? _____

What are the deductibles or co-payments in the employer's plan? _____

Hospital deductible or co-payment _____

Emergency room or hospital outpatient deductible or co-payment _____

Medical deductible or co-payment _____

Other deductibles or co-payments _____

Does the employer's plan provide dental, eyeglasses, hearing or other benefits? _____

Does the plan require the use of participating or preferred providers? _____

Does the plan provide a prescription drug benefit? How does it work? _____

Is there a stop-loss or out-of-pocket limit? _____

How much does the employer's plan cost per month? _____

FOR ASSISTANCE IN UNDERSTANDING YOUR SPECIFIC BENEFITS AND THEIR COORDINATION WITH MEDICARE, CONSULT A SHINE COUNSELOR.
CALL (800) 882-2003

3. MEDIGAP or MANAGED CARE?

"What are my alternatives if, after 65 I decide to retire, or my health insurance becomes too expensive?"

First, you'll need to enroll in Medicare. If your employer group coverage is terminated or you stop working, whichever comes first, you will have **eight months** in which to enroll in Medicare without a penalty surcharge.

Once you have Medicare, like most people you will probably want additional health coverage that helps pay for what's not covered by Medicare. Keep in mind, no system of enhancing Medicare coverage is right for everyone. All plans have benefits and limitations which must be evaluated relative to your lifestyle and personal preferences.

As a Medicare beneficiary you can choose to receive your Medicare benefits **either** through the fee-for-service system or through a managed care plan such as a Health Maintenance Organization (HMO).

Medicare Supplements

Medicare supplemental insurance, also known a **Medigap** insurance, is designed to help fill in some of the gaps in coverage left by Medicare. A Medigap policy is an indemnity or fee-for-service policy. This means you may choose any doctor, specialist, or hospital you wish. When you buy a Medigap policy, you must have both Medicare A & B. You must pay monthly insurance premiums and may still have to pay for some Medicare deductibles and co-payments. The plans that cover the costs of prescription medications may have claims forms.

Medicare Managed Care Plans (including Medicare HMO's)

When you join a Medicare-contracting HMO, you will continue to pay the monthly Medicare Part B premium. Depending on the plan, you may also pay a monthly premium and small co-payments for office visits, prescription drugs and other services. Generally, you must receive all covered services from the doctors, hospitals, and other health care providers that are part of the HMO's network for the HMO to pay. Some exceptions include emergency care, urgent care outside the HMO service area, and care authorized by the HMO or your primary care physician.

> Regardless of whether you choose fee-for-service or managed care, you retain all of your Medicare benefits, protections and appeal rights.

"MEDIGAP" (MEDICARE SUPPLEMENT INSURANCE)

"Don't all Medicare enrollees need a Medigap insurance policy?"
No! Not everyone needs a Medicare Supplement (Medigap) health insurance policy.

Who should purchase?
A privately-purchased Medicare Supplement, often called a "Medigap" policy may be a necessary piece of health insurance:

- if you do not have a retiree plan, or if your retiree plan is extremely limited in coverage or
- if you are not eligible for Medicaid or Medicare's Buy-In Programs (QMB, SLMB).

Who can purchase?

- must be eligible for Medicare Part A & B and enrolled in Medicare Part B,
- must be a resident of Massachusetts at the time of purchase, and
- if under the age of 65, cannot have End Stage Renal Disease,

Medigap options?
There are currently three standard Medigap plans available for sale in Massachusetts from both commercial and not-for-profit companies. They are named **"Core", "Supplement 1", and "Supplement 2"**. Companies may use additional brand names, too. These plans range in cost from $480 to $3,000 per year per individual.

There will still be medical costs that neither Medicare nor your Medigap policy will pay. But, with Medicare plus a Medigap policy, you'll have protection against large out-of-pocket costs for hospital and physician bills.

Use caution when:

- *Replacing your old Medigap policy* - All companies must use consistent labeling of their plans. This labeling is Core, Supplement 1 and Supplement 2. The benefits are virtually identical for each "type" of plan. For example, Supplement 1 offered by one company has the same coverages and benefits as Supplement 1 offered by another company. This makes comparing plans easier. It's the company's premiums and customer service that vary!

- *Canceling your current Medigap policy* - Keep in mind, the plan you now have may no longer be approved for sale in Massachusetts. Therefore, if you cancel it and then change your mind, you may not be able to switch back.

- *Buying more than one Medigap policy* - It is illegal for an insurer to sell a duplicate Medicare Supplement policy to an individual who already has a privately-purchased

Medicare Supplement policy. But, it is permissible for an insurer to sell a Medigap policy to someone who has an employer-sponsored retiree plan.

Medigap too costly?

If you now have a Medigap policy and the premium is becoming too costly, be aware that you may:

- downgrade to a lower cost plan with your current insurance company,
- or during open enrollment, switch to another company offering similar Medicare supplement insurance with a lower premium.
- compare the benefits and costs of Medicare HMOs in your area.
- contact your local Division of Medical Assistance to determine if you qualify for Medicaid, QMB, or SLMB.
- Explore other free and discounted health care programs available for seniors in Massachusetts.

Basic Facts about Massachusetts Medicare Supplement Insurance

⇒ **Simplification:** Insurers who wish to sell policies in Massachusetts must sell Core and Supplement 2, and may sell all three standard plans. Remember, you should only purchase one Medicare supplement policy.

⇒ **Coverage:** Duplicate coverage is expensive and unnecessary. Agents are prohibited from selling you a Medicare supplement policy if you already have one and you do not want to replace it.

⇒ **Pre-existing conditions:** If you meet the eligibility requirements and apply during open enrollment (see page 15), an insurer is not allowed to impose any waiting period for pre-existing conditions.

⇒ **Renewals:** All individual Medicare supplement plans sold in Massachusetts must be "**guaranteed renewable**". State law prohibits companies from canceling these policies except for non-payment of premium or for incomplete or incorrect information on your original application.

⇒ **Open Enrollment:** Federal and state laws require all companies to sell their policies during specific "**open enrollment periods**" to all who want to buy a policy. If you enroll during these enrollment periods, the company must accept your application regardless of your medical history, health status or claims experience and cannot discriminate in the pricing of the policy based upon these factors.

⇒ **Free Look Provision:** Beginning the day you receive the approved policy, you have 30 days to look it over. If you change your mind, you can cancel the policy within those 30 days and get a full refund.

Read more about Medigap insurance: For a copy of "*The Massachusetts Guide to Health Insurance for People with Medicare*", call the Division of Insurance at 1-617-521-7777, or the Executive Office of Elder Affairs SHINE program at 1-800-882-2003

"When can I enroll in a Medigap plan?"

Your age is:	And you are:	You can enroll in any Medigap plan approved for sale in Mass*:
Under 65	Enrolling in Medicare due to a disability other than end-stage renal disease	**Within six months** of your effective date for Medicare Part B Note, you will also have another six **months** to enroll when you turn 65 and are already on Medicare Part B
Approaching 65	Enrolling in Medicare during your initial seven-month enrollment period	Up to **three months** before the month of your 65th birthday and within ***six months*** of your effective date for Medicare Part B
Over 65	Retiring from an employer-sponsored health plan and/or enrolling in Medicare Part B	Within **six months** of your effective date for Medicare Part B
Any age and enrolled in Medicare Part B (except if you are under age 65 and on Medicare solely due to end-stage renal disease)	Losing an employer-sponsored health plan because your job ended or your employer stopped offering health coverage to employees like you **or** Covered by an HMO but are moving out of the HMO's service area **or** Becoming a resident of Massachusetts **or** Interested in purchasing Medigap	Within **six months** of loss Within **six months** of move Within **six months** of move Every **February and March** each year and coverage is effective June 1st. In addition, Medigap insurers may have open enrollment periods during other times of the year or all year long (continuous open enrollment).

Under the circumstances and open enrollment periods listed in this chart, a Medigap insurer must accept your application and cannot impose a waiting period or charge you a premium based on your age or health condition.

***You must live in Massachusetts. You must be eligible for Medicare Part A and Part B and enrolled in Medicare Part B. If you choose to replace a current Medigap policy, you must sign a statement indicating that you are replacing a Medigap policy and will not keep both policies.**

1998 Monthly Premiums for Medicare Supplement Insurance

Please Note: Rates may change in 1998. Call company for current rates.

Insurance Company	Time of Year Selling *	Core	Supplement 1	Supplement 2
Blue Cross & Blue Shield 1-800-258-2226 1-617-376-4700 Offers discount to persons who enroll when initially eligible for coverage (see explanation below).	Annual Open Enrollment Period of February and March or Any Time in Year only for Persons who are "Initially Eligible for Coverage " - See definition below*	$57.22 As of 3/15/98	$106.87 As of 3/15/98	$260.48 Drug Mail-Order Option As of 3/15/98
Hartford Life Insurance ** For Retired Officers Association and Association of the United States Army only TROA: 1-800-247-2192 AUSA: 1-800-882-5707 No premium discount program.	Continuously Throughout Year - Open Enrollment	$41.00	$74.00	$139.00
Lincoln National Life Insurance Co. ** For Military Benefit Association members only 1-800-336-0100	Continuously Throughout Year - Open Enrollment	$53.09	$78.19	$116.30
United HealthCare ** For American Association of Retired Persons (AARP) members only 1-800-523-5800 Offers discount when using automatic bank withdrawal.	Continuously Throughout Year - Open Enrollment	$55.75 As of 4/1/98	$105.75 As of 4/1/98	$238.25 As of 4/1/98

A 6-Month Open Enrollment period goes into effect for persons who are "Initially Eligible for Coverage", meaning someone who just enrolled in Medicare Part B; or someone who just moved to Massachusetts; or someone who was covered by an HMO but just moved out of the previous plan's service area; or, someone who has lost their health insurance coverage from their employer because their job ended or their employer stopped offering coverage to employees like them. Persons who are initially eligible for coverage can enroll anytime during their special 6- month enrollment period.

** These plans are only available through membership in the associations indicated. See next page for important membership information.

Membership information for associations sponsoring Medigap insurance is printed below:

Hartford Life Insurance Company /Association of the United States Army (AUSA) - Call 1-800-882-5707 request both membership and application materials. Any civilian may become a member of the AUSA, including those without any military background. Active army personnel may also join the AUSA. Membership fees are currently $33.00 per year.

Hartford Life Insurance Company /The Retired Officers Association (TROA) - Call 1-800-247-2192 to learn more about membership. Membership is limited to commissioned officers and their spouses or widows/widowers.

Lincoln National Life Insurance/ Military Benefit Association (MBA): Call 1-800-336-0100 for membership information. Membership is limited to living military retirees and their spouses only; not available to widows of military retirees. Coverage also limited to those individuals who previously had a CHAMPUS supplement prior to turning age 62.

United Health Care /American Association of Retired Persons (AARP) - Call 1-800-424-3410 to request membership materials. To be a member, one must be at least 50 years of age. AARP switched its group health coverage from Prudential to United HealthCare Insurance Company on 1-1-98; all previous Prudential policyholders are now covered by United HealthCare. Prudential stopped selling new AARP policies as of 12-31-97.

Three Standard Medigap Plans Sold in Massachusetts - 1998

Comparison of Plans	Core	Supplement 1	Supplement 2
Basic Benefits Included In All Plans:			
Hospitalization Part A Co-payments			
Days 61 - 90: $191 per day	X	X	X
Days 91-150: $382 per day	X	X	X
365 Additional Lifetime Hospital days - Paid in full	X	X	X
Part B Coinsurance -			
Coverage of coinsurance, in most cases, 20% of approved amount	X	X	X
Parts A and B Blood First 3 pints	X	X	X
Additional Benefits	**Core**	**Supplement 1**	**Supplement 2**
Part A Deductible for Hospital Days 1 - 60 $764 per benefit period		X	X
Skilled Nursing Facility Coinsurance Days 21-100 - $95.50 per day		X	X
Part B Annual Deductible - $100.00		X	X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X	X
Inpatient Days in Mental Health Hospitals In addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period	120 days per benefit period
Outpatient Prescription Drugs ** From Retail Pharmacies after a you meet a $35 calendar quarter deductible: • 100% coverage for generic drugs • 80% coverage for brand-name drugs			X
State-Mandated Benefits: Annual Pap Smear Tests and Mammograms. Check your policy for other state-mandated benefits	X	X	X

** These drugs include: insulin needles and syringes; pumps and pump supplies necessary for the administration of insulin and materials, and equipment used to test for the presence of sugar; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs.

MEDICARE MANAGED CARE PLANS (HMO's)

"My Medigap plan with prescription coverage is getting too expensive. But I need more coverage than Medicare alone!"

The growth of HMOs (health maintenance organizations) has made managed care a viable choice for many Medicare beneficiaries. Today, a managed care plan can be an affordable option to fill Medicare gaps and enhance your health coverage.

What is "Managed Care"?

Managed care combines the functions of both health insurance and health services in one organization. It offers, on a pre-paid basis, medical and preventive services through a network of designated hospitals, doctors and other providers. An HMO is a managed care plan.

How do Medicare HMOs work?

When you enroll in a Medicare HMO, you are signing up to receive all your Medicare services through the HMO. Medicare prepays a monthly fixed amount to the plan In return, the HMO is required to provide all of the services you would be entitled to under Medicare coverage. Additional benefits such as periodic checkups, health screenings, vision services, prescription drugs, dental visits, hearing exams, eyeglasses and/or wellness programs may also be covered.

HOW MEDICARE HMOs WORK

- offer a full range of Medicare-covered services plus more from a network of doctors, hospitals, nursing homes and other health care providers/facilities
- access to services coordinated by primary care physician
- low or zero premium depending on the plan
- you must continue to pay your Part B premium to Medicare
- co-payments (generally $5 to $10 per visit)
- virtually little or no paperwork
- supplemental (Medigap) policies not needed

It's wise to compare benefits and costs. Some HMO plans charge you a fixed monthly premium while others offer a "*zero premium*" plan. Small co-payments may apply when you receive certain services such as office visits. (See HMO comparison chart beginning on page 25). When you join an HMO plan, that plan provides the care and processes most of

the paperwork internally. In most cases, there are no claim forms or confusing reimbursement schedules.

Choosing your Primary Care Physician

Some seniors shy away from HMOs because of the requirement that they use the HMO plan's staff of physicians. However, this is not necessarily a limitation because many physicians participate in both HMO's as well as the fee-for-service system. Ask your primary doctor or specialists if they participate in a Medicare Managed Care Plan - they just might!

Upon joining an HMO, you will be asked to choose a primary care physician from a list of doctors who work for or are associated with the HMO. Your doctor is responsible for coordinating all your health care. Primary care physicians provide routine medical care, refer you to specialists within the network (in most cases), and arrange for hospital admissions.

- **When you enroll, you must choose a primary care physician** from the HMO's directory or one will be assigned to you.
- **HMO plans with Medicare contracts are required to provide access to** a sufficient number of physicians to satisfy the needs of its membership. It is important to ask if the primary care physician you want is currently accepting new patients.
- **All HMO plans must allow you to switch physicians** if you're not satisfied with the care you're getting. You may pick another one from the plan's network.

Medicare Contracts with HMOs to Provide Medicare Covered Services: "Risk" or "Cost"

Under an HMO plan with a **"risk contract"**, there is a **Lock in provision,** which means members are required to use the plan's network of providers and facilities only. If you receive services outside the plan's network, **neither** the plan ***nor*** Medicare will pay. You will be responsible for **all of the charges** for the out-of-network provider. The only exceptions are for emergencies, urgently needed care while temporarily outside the plan's service area, or when you receive prior approval from your primary care physician or HMO to see a specific medical provider outside the HMO's network.

If you enroll in an HMO plan with a **"cost contract"** with Medicare, you **can use** health care providers outside the plan. However, if you use a provider outside the HMO's service area for non-emergency services, your bill will go to Medicare, and after Medicare pays its share for covered services, you will be responsible for the Medicare deductibles, co-payments and in some cases, excess charges.

Do HMOs cover emergency care?

All HMO plans with Medicare contracts must cover emergency care as part of the basic benefit package. HMO plans will pay if you have a medical emergency or an urgent need for care while you are temporarily out of the HMO's service area. However, they won't pay for routine care, or care you could have planned in advance.

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"How do I choose an HMO?"

Look at the "**HMO Comparison Chart**" on the next page to learn more about which Medicare HMOs are available, their service area, and how each plan differs in premiums and co-payment costs. Then, contact the HMO at the address shown or by phone to get additional information.

Before you join, be sure to read the HMO's membership materials carefully. Learn your rights and the extent of your coverage. If you live in an area served by more than one HMO, compare benefits, costs and other features to find which best suits your needs at a price you can afford. Also, find out which type of contract (risk or cost) the HMO has with Medicare.

"Who can enroll in a Medicare HMO?"

You may enroll in a Medicare HMO if you:

- **are enrolled in at least Medicare Part B and pay the Part B premium**
- **live in the HMO's service area**
- **do not have end stage renal disease**
- **are not receiving Medicare hospice benefits**

How do I enroll in a Medicare HMO?

The only way to enroll with the HMO is with the plan itself. You will need to complete the HMO's "**enrollment application**" and submit it to the HMO. To get an application form, call the HMO or stop by an HMO sales presentation.

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When can I enroll?

Currently, all Medicare-contracting HMO plans available for sale in Massachusetts offer **continuous** open enrollment. If you meet the four eligibility requirements listed in the box above, you can enroll in any HMO plan that serves your area **anytime**. HMOs cannot refuse to enroll you if you have health problems, except for kidney failure, end-stage renal disease, and hospice care.

Your enrollment may take effect either the first day of the month after the HMO receives your application or up to three months later. Once your enrollment is effective, familiarize yourself with the HMO's rules. Some consumers fail to use plan providers, and if they are in a risk HMO, end up with unexpected medical bills. All HMOs will notify members when their coverage is effective.

Consumer Rights For Medicare Beneficiaries Enrolled in HMOs: Appeals, Grievance Rules, and How to Disenroll

"What if I'm not happy with my Medicare HMO?"

If you have a complaint about the quality of care you receive, you can follow your HMO's grievance procedure. You'll find the grievance procedures outlined in the plan's member handbook. Or you can file a "**Quality of Care Complaint**" with the Massachusetts Peer Review Organization (MassPRO) by calling their Hotline at **1-800-252-5533.**

What should I do if my HMO refuses to provide or pay for a service?

If the claims department denies payment for Medicare-covered services or the HMO refuses to provide the services you feel are medically necessary, ask the HMO to put it in writing. The "**Notice of Initial Determination**" will include an explanation of your appeal rights.

You have the right to appeal a denied claim or a denied request for medical services. To appeal, notify the HMO in writing within *60 days* after you receive the "**Notice**". You can simply make a copy of the notice, write "**please reconsider**" on it, and sign your name. Then mail it or deliver it to the HMO or to a Social Security Office.

If the HMO does not rule in your favor, they must automatically submit your appeal to **The Center for Dispute Resolution** for further review and a determination. If the Center agrees with the HMO and the amount in question is $100 or more, you will have 60 days from the receipt of the second determination to request a hearing before a Social Security Administrative Law Judge. If your case involves $1,000 or more, you can eventually appeal to a Federal Court.

Expedited Appeal Process

HMO members can request a fast appeal (using the expedited appeal process) whenever the member feels the plans decision could seriously jeopardize the life or health of the member or the members ability to regain maximum function. Using a fast appeal process, health plans are required to conduct a review within a time period appropriate to the condition or situation of the member, but not more than 72 hours from the time of the request.

The member or his/her representative can request the fast appeal either by telephone or in writing. Physicians can request an expedited review on behalf of a member and the health plan must perform a fast review.

Sometimes, when a member asks for a fast appeal, the plan can refuse the request if they do not think the charge or denial in services would seriously jeopardize the members health or ability to regain maximum function. This decision can be appealed. For more information on the appeal process, contact your HMO plan.

Early hospital discharge - (What can you do if you are in the hospital and are told you will be discharged because your stay will no longer be covered?) The HMO must give you written notice called a "Notice of Non-Coverage". You have the right to request an immediate review by calling MassPRO at 1-800-252-5533 by noon of the next business day after the date on this Notice. While MassPRO reviews the discharge decision, you will not be responsible for the additional days stay.

"How can I disenroll from my Medicare HMO?"
You may cancel your membership for any reason by telling the HMO in writing you want to leave the plan. Sign and date your request and send it to the HMO office or to the Social Security Office. It may be a good idea to send it certified mail (return receipt requested) if you want a record of when you sent it. Keep a copy of your letter. Your coverage under the Medicare fee-for-service system will begin the first day of the following month the HMO or Social Security received your request.

To learn more about your rights to care as a Medicare beneficiary, contact your managed care plan, or read the booklet titled A Massachusetts Guide to Medicare and Medicare HMO APPEALS, available from your local SHINE Program or the Executive Office of Elder Affairs, 1 Ashburton lace, 5th floor, Boston, MA 02108. 1-800-882-2003 or TDD: 1-800-872-0166.

Please Note: Rates may change in 1998 as these rates are subject to federal approval and state review. Ask company for current rates.

Medicare HMO Plan Name, Address and Phone	Time Enrolling New Members *	Monthly $ Premium $ Without Prescriptions	Monthly $ Premium $ With Prescriptions	Office Visit Co-pay to Primary MD	Prescription Co-Payment*** for Prescription Drugs	Service Area by Counties	Type of Contract * Risk or Cost
Aetna U.S. Healthcare 400-1 Totten Pond Road Waltham, MA 02154 1-800-991-9555	All Year	$80 - "Medicare Premier" $10 - "Medicare V" $0 - "Medicare X"	$145 -"Medicare Premier w/drug" $75- "Medicare V w/drug" $65- "Medicare X w/drug"	$2 or $5 or $10	$10 Mail Order Too	Barnstable, Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester (and towns of Orange and Ware)	Risk
Fallon Community Health Plan 10 Chestnut Place Worcester MA, 01608 1-508-831-0712	All Year	$0 "Senior Saver"	$72.50 "Senior Preferred"	$5	$2 or $5/30 days $6 or $15/90 days. Mail Order too	Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Worcester	Risk
Harvard Pilgrim HC, Inc. 3 Allied Drive Dedham, MA 02026 1-800-779-7723	All Year	$0 to $61 "First Seniority"	$71 to $132 "First Seniority with Drug benefit"	$5	$8 for Generic and $15 for Brand. Mail Order too	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester	Risk
Harvard Pilgrim HC of New England, Inc. 1 Hoppin Street Providence, RI 02903 1-800-835-5522 ext. 51406	All Year	$65 "Care Plus"	$112 "Care Plus with Drug benefit"	$5	$5/30 day supply. $10/90 day supply. Mail Order too	Bristol, Middlesex, Norfolk, Plymouth, Worcester	Cost
HMO Blue of Blue Cross and Blue Shield of Massachusetts 100 Summer Street Boston, MA 02110 1-800-678-2265	All Year	$0 to $30 "Blue Care 65 Value"	$75 to $105 "Blue Care 65 Value Plus"	$5	$5 at Health Center or $8 for Generic and $15 for Brand at Retail Pharmacy. Mail Order too	Barnstable, Bristol, Essex, Middlesex, Norfolk, Suffolk, Plymouth, Worcester, Franklin, Hampden and Hampshire	Risk
Tufts Associated Health Plan 333 Wyman Street Waltham, MA 02254 1-800-246-2400	All Year	$0 "Secure Horizons"	$74 "Secure Horizons with Pharmacy Coverage"	$5	$8/30 day supply $15/90 day supply. Mail Order too	Barnstable, Essex, Hampden, Norfolk, Middlesex, Plymouth, Suffolk, Worcester	Risk
United Health Plan of New England 475 Kilvert St., Suite 310 Warwick, RI 02886-1392 1-800-448-4481	All Year	$0 - "Medicare Complete" $49 - "Medicare Complete w/dental"	$124 - "Medicare Complete w/ drug" $173 - "Complete with drug & dental"	$5	$10 No Mail Order Option	Bristol, Norfolk, Worcester	Risk

***ENROLLMENT PERIODS** - All new applicants (people not currently enrolled with the non-drug plan of the HMO) may enroll throughout the year into any plan offered by an HMO. While most Medicare HMOs restrict enrollment to February and March only for current plan members who want to change ("upgrade") from the non-drug plan to the plan with outpatient prescription drug coverage, Aetna U.S. Healthcare allows existing members to upgrade at any time of the year.

****RISK VERSUS COST CONTRACT** -

- A Medicare HMO with a Risk Contract requires enrolled members to receive all non-emergency services through the HMO's network of providers; with few exceptions related to emergencies or urgently needed care, neither the plan nor Medicare will pay for Medicare-covered services received apart from the plan. This feature is referred to as the "Lock-In Provision."
- A Medicare HMO with a Cost Contract allows you to receive Medicare-covered services outside of the plan's network of providers; when this occurs, Medicare will pay its portion for the Medicare-covered services but the HMO does not pay anything towards the Medicare deductibles and co-insurance amounts.

*****OUTPATIENT PRESCRIPTION DRUGS** - Massachusetts requires each Medicare HMO to sell a plan that covers outpatient prescription drugs. The drug benefit can have a co-payment amount of up to $8 dollars for generic drugs and up to $15 dollars for brand drugs, OR, a co-payment of up to $10 for both generic and brand name drugs. Also, some HMOs have a different co-payment amount depending on whether you buy the drugs at one of the plan's health centers or at an independent pharmacy, or based upon the number of days for the prescription (such as 30 or 90 days). The total dollar value of drugs that you can receive is unlimited. An HMO may offer a mail-order program for outpatient prescription drugs with its drug plan, but it is not required to do so. The HMO may limit the mail-order companies from which you can order the drugs. You should contact the HMO directly to find out more about their mail-order program.

WHO MAY ENROLL IN A MEDICARE HMO? You may enroll in a Medicare HMO plan that has a Risk or Cost Contract if you meet the following 4 requirements: **1)** you live in the plan's service area, **2)** you have Medicare Part B, **3)** you do not have permanent kidney failure and you are not receiving kidney dialysis services (If you have kidney disease and you are currently enrolled in a non-Medicare HMO, you will be able to convert to that HMO's plan for people with Medicare. Contact your HMO for information.), and **4)** you have not elected the Medicare hospice benefit for terminally ill persons. A Medicare HMO cannot conduct further health screening and cannot exclude any applicant based solely upon their age. So, apart from the exceptions noted above, Medicare beneficiaries of any age with developed health problems cannot be excluded from HMO enrollment.

PLAN COSTS - WHO DECIDES HOW MUCH THE PREMIUM SHALL BE?

Premium rates for Medicare HMO plans are reviewed by the federal Health Care Financing Administration and the Massachusetts Division of Insurance. Medicare HMO plans do not charge premiums based upon your age or health condition. However, HMOs may charge a different premium based upon where you live. This is called "community rating."

ADDITIONAL HEALTH CARE BENFITS AVAILABLE FROM MEDICARE HMOs

Medicare HMOs must provide all Medicare-covered benefits, and cover the Medicare deductibles and coinsurance amounts. In addition, a Medicare HMO may provide other health care services not covered under Medicare, such as annual routine physicals, eye exams, payment for eyeglasses, hearing exams, hearing aids, or dental care. Contact the plan to learn about what additional preventative service benefits they provide.

BENEFITS COMPARISON CHART

BENEFIT	EMPLOYER PLAN NAME OF PLAN	MANAGED CARE NAME OF PLAN	MEDIGAP PLAN NAME OF PLAN	OTHER NAME OF PLAN
Hospital Deductible				
Medical Deductible				
Hospital Co-payments				
Medical Co-payments				
Annual Out-of-Pocket Limit				
Prescription Drugs				
Foreign Travel/Out of Area				
Monthly Premium				
Preventive Care (besides flu shots, mammograms)				
Out-of-Pocket Maximum				
OTHER _____ *(Eye exam, glasses, hearing aids)*				

4. MEDICAID, QMB & SLMB - Health Insurance or Help Paying for Medicare Costs for People with Low Incomes

"I'm living on a fixed income and I can barely afford Medicare, much less any other insurance!" If you have Medicare, but find it difficult even to pay the monthly Part B premium, you may be eligible for one of three government assistance programs. Any of these pieces of health insurance coverage may be tremendously helpful as they will pay for medical costs for low income Medicare beneficiaries.

Medicaid Health Insurance Coverage

Medicaid wraps around your Medicare coverage to pay many of the gaps in Medicare, such as premiums, deductibles, co-payments, and extras like prescription drugs and eyeglasses. You may enroll into Medicaid if:

- for an individual, your income is **$691 or less** per month and your assets are **$2,000 or less.**
- for a married couple, your income is **$925 or less** per month and your assets are **$3,000 or less.** (Different asset and income rules are used when a married person needs Medicaid for nursing home care.)

Qualified Medicare Beneficiary Program (QMB)

QMB pays the Medicare premiums, deductibles, and co-payments. No extra medical benefits are covered, but QMB would pay the cost of a Hospital Deductible ($764 in 1998), the part B annual $100 deductible, and all the 20% co-payments for Part B services like doctors' bills. You can enroll into QMB if:

- for an individual, your income is **$691 or less** per month and your assets are **$4,000 or less.**
- for a married couple, you income is **$925 or less** per month and your assets are **$6,000 or less.**

Specified Low-Income Medicare Beneficiary Program (SLMB)

SLMB pays only your Medicare Part B premiums. This single benefit is significant. You'll save $510 each year in Medicare premiums alone if you enroll. You may be eligible if:

- for an individual, your income is **$825 or less** per month and your assets are **$4,000 or less.**
- for a married couple, your income is **$1,105 or less** per month and your assets are **$6,000 or less.**

Note, the asset limits listed above for Medicaid, QMB and SLMB do not include your home, automobile and certain burial funds and contracts.

To learn more about Medicaid, QMB, and SLMB: Contact a MassHealth Enrollment Center to determine if you qualify for any of these programs. For an application, call the Medicaid Customer Service Hotline at **1-800-841-2900.**

"What do I need to do to apply for Medicaid?"

To apply for Medicaid, QMB, or SLMB, call the MassHealth Customer Service Hotline at 1-800-841-2900 or any of the four MassHealth Enrollment Centers listed below to ask for an application form (UNIV-1).

Charlestown MassHealth Enrollment Centers	800-662-9996
The Schraffts Center	(617) 248-4200
529 Main Street	TTY: 800-608-3300
Charlestown, MA 02129	(617) 248-4335 (Fax)
Springfield MassHealth Enrollment Center	800-332-5545 or 800-321-2007
311 State Street	(413) 785-4100
Springfield, MA 01105	TTY: 800-596-1276
	(413) 785-4180 (Fax)
Taunton MassHealth Enrollment Center	800-242-1340
	(508) 828-4600
21-A Spring Street	TTY: 800-596-1272
Taunton, MA 02780-0711	(508) 828-4611 (Fax)

You will need to complete and mail the application form to any of the three MassHealth Enrollment Centers listed above. If you prefer to meet with a Medicaid worker, you can stop by any of the Centers. You should receive a letter from the Division of Medical Assistance indicating what documents or verifications will be needed to process your application. When all your paperwork is complete, a decision should be made within 45 days.

There is also a MassHealth Enrollment Center in Tewksbury that will assist clients who wish to walk-in and apply for Medical Assistance. Also, once your application is approved and you have any questions or problems concerning Medicaid, the Tewksbury office will have your records.

MassHealth Enrollment Center in Tewksbury	
367 East Main St.	800-408-1253 or 508-262-9100
Tewksbury, MA	800-231-5698 TTY
01876-1957	508-262-9212 (Fax)

5. LONG TERM CARE INSURANCE

"How will I pay for long-term care?"

Long-term care is the name given to the medical, personal, and social services you might need if, because of an accident, an illness, or just growing frail, you are unable to perform certain functions *independently or on your own* for an extended period.

Long-Term Care is expensive!

Long-term care is one of the most expensive, but least covered health care costs you may encounter. In Massachusetts:

- Nursing home care can cost $36,000 to $75,000 per year
- Home health care can cost $40 to $50 per visit
- Adult Day Care can cost $30 to $50 per day

Most pieces of health insurance cover very little of the cost of long-term care.

- Medicare pays a maximum of 100 days of nursing home care and a certain amount of home health care only if you need skilled care. Only 2% of Medicare enrollees who need nursing home or home health care meet Medicare's strict requirements for coverage.
- Retiree plans may pay the Medicare coinsurance for nursing home care for a short period.
- Medigap policies pay only the Medicare coinsurance (days 21-100) per benefit period for skilled nursing facility care.
- Medicare HMO plans usually pay up to 100 days per benefit period for skilled nursing facility care.

Will Medicaid pay for long-term care?

Medicaid will pay long-term care costs in a nursing home and sometimes at home as well. But Medicaid is available only when single persons have no more remaining in assets than $2,000. If you are married, your spouse living at home would be permitted to keep up to $80,760 (or more, after an appeal), of your joint assets as well as $1,353 to $2,019 of income monthly as a spousal maintenance needs allowance.

Is long-term care insurance the answer?

Should everyone have long-term care insurance to pay for long-term care costs? Ideally, yes. But long-term care insurance, like the long-term care services you are insuring against, is expensive. So, long-term care insurance is only appropriate for those who can afford the premiums, both now and in the future. It is *not* appropriate for those whose assets total are less than the cost of one year in a nursing home.

Favorable tax treatment affecting long term care insurance policies and uninsured long term care expenses. Favorable tax treatment may be available for certain types of long term care expenses and policies for. For example:

- premiums for **qualified** insurance policies will be deductible as medical expenses (for those who itemize medical deductions);
- LTC benefits received from **qualified** policies may be received by the insured policy holder on a tax-free basis;
- uninsured LTC expenses **not covered by insurance** may be deductible as medical expenses (under certain restrictions);
- Employer-paid premiums of LTC insurance may not be treated as income to the insured employee.
- Tax-qualified plans must coordinate with Medicare; so if Medicare pays for a service first, the LTC policy would pay as a secondary payer for the same service.
- A nonforfeiture benefits option must be offered during the sale of all qualified policies. This does not mean the benefit will be a standard feature built into every policy.

The IRS must finalize definitions for qualified policies and submit which would get such treatment. See a tax advisor for details.

There is no general rule for everyone to use to determine whether long-term care insurance is suitable. When deciding whether long-term care insurance is appropriate for *you*, consider the following:

- **Your ability to afford long-term care insurance.** Senior advocates suggest that a long-term care insurance premium that exceeds 5% to 7% of your annual income is probably unaffordable.
- **Your ability to qualify for a long-term care insurance policy.** Unless you are in relatively good health, insurers probably will not sell you a long-term care insurance policy.
- **Your goals.** Do you wish to preserve assets for a spouse or to leave an inheritance to your children?
- **Your health status, lifestyle, family history, life expectancy.** Do you expect chronic conditions?
- **Your gender, your marital status.** Are you female, single or widowed? Your chances of needing formal long-term care services are greater when informal (unpaid) help with long-term care is not available to you.
- **Your support circle.** Are your family and friends in distant locations or otherwise unable to provide care if you should need it? Long-term care insurance may make sense.

Read more about long-term care insurance:
For a copy of "A Shopper's Guide to Long-Term Care Insurance", contact the National Association of Insurance Commissioners at 1-816-374-7259 or write to: NAIC, 120 W. 12th Street, Suite 1100, Kansas City, Missouri, 64105.

"A Massachusetts Consumer's Guide to Long-Term Care Insurance" and a "LTC Self-'Assessment Guide" with Bibliography may be obtained by calling the Executive Office of Elder Affairs at 1-800-882-2003 (TDD: 800-872-0166) or the Division of Insurance at 1-617-521-7777 (TDD: 617-521-7490). A Long Term Care Self-Assessment Questionnaire and Bibliography of Resources is also available from the Executive office of Elder Affairs.

6. NON-GROUP HEALTH INSURANCE FOR INDIVIDUALS

Non-Group Health Insurance Plans for Individuals and Families in Massachusetts

Massachusetts residents who are not eligible for employer-based health coverage may buy non-group health care insurance or coverage from any carrier offering plans. As of October, 1997, carriers offering this coverage will not be able to refuse any applicants based on their health, and carriers cannot impose pre-existing condition exclusions or waiting periods. And, all carriers must offer one of three model coverage packages.

Who is eligible?

Individuals and their dependents are eligible for this coverage if :

- they are Massachusetts residents;
- they do not have access to group health insurance through their employer or spouse's workplace;
- they are not eligible for COBRA coverage, or are no longer eligible for COBRA coverage;
- they are not enrolled in Medicare or Medicaid; and
- they are not self-employed. (Under Massachusetts law, self-employed persons are not eligible for non-group health coverage because they may buy coverage from any insurance carrier which offers coverage to small business).

When to enroll

There is an Annual Enrollment Period, 2 months in length, held September 1 - October 31, with coverage to be effective on December 1st.

3 Model Coverage Packages for Non-group Plans

Under Massachusetts law, carriers must offer a plan (or plans) that includes a standard set of benefits including emergency care, hospital services, physician services, certain

preventive treatments, and outpatient prescription drugs. Carriers may offer more than the standard stet of benefits. Carriers may also charge deductibles before reimbursing for services, and may also charge co-payments for services covered under the plan. However, these deductibles and cost-sharing co-payments cannot be greater than the amounts approved by the Division of Insurance.

The three types of plans vary according to their structure and how they deliver medical services.

The first is the **Medical Plan.** The medical plans do not have any restrictions on choice of medical providers. This is a traditional health plan in which the insured may go to any licensed hospital, doctor, or provider for treatment. Under the non-group standard requirements, the insured must meet an annual deductible for $700 per member/$1,400 per family, and then pay 20% of the cost for most covered services.

The second model plan is the **Preferred Provider Plan,** which contains incentives for using a set of preferred providers. In a preferred provider plan, the insured may go to any licensed hospital, doctor or provider, but he will pay a smaller co-payment if he visits medical providers listed on the preferred list of providers. Under this model plan, the insured must meet an annual deductible of $250 per member/$500 per family and then pay 10% of the cost of covered services from the preferred providers and 30% of the cost of services received from other non-preferred providers.

The third and final model plan is the **Managed Care Plan**, offered by HMOs with closed networks of providers. Except in cases of emergency and specific situations, the insured must use the providers of the HMO network in order to receive benefits. In this standard model plan, there is no deductible. There are co-payments ranging from $15 for each office visit to $500 for a hospital stay.

"Guarantee Issue Plans" Means No Health Screening

The participating health insurance carriers cannot deny any applicant nor impose any waiting periods or coverage limitations because of medical conditions or prior medical history. They can only deny coverage if the applicant does not meet all the application criteria listed above, or if an applicant lives outside the service area (for plans where residency within the plans' service area is relevant), or if the insured does not pay the plan premiums, or, if the carrier learned hat the insured submitted false information on their application or other plan documents, such as claim forms.

Cost for Non-group Health Insurance Plans

Carriers will offer a plan with rates that will vary based upon the applicant's age, family type (both individual and family coverage is available), and place of residence.

For More Information and a List of Current Carriers

You or our client may contact the Division of Insurance at 617-521-7777 (Boston) or 413-785-5526 (Springfield) (or TDD: 617-521-7490) for information about pricing, and a list of approved plans for families in your area of the state. During 1997's initial enrollment period, 23 separate plans were available from 19 different carriers.

"Are extra limited benefit policies necessary?"

As of 10/1/97 limited benefit policies can no longer be sold in Massachusetts. The only plans that can be sold are non-group "guarantee issue" health insurance plans.

Check the limited benefit policy that you already have. Many people buy indemnity policies years before Medicare enrollment and neglect to evaluate whether or not the policy is necessary when they become eligible. Many hospital plans reduce benefits by 50% after age 65!

Use great caution in any health insurance policy purchase to avoid paying for coverage you may not need. **Choose what you need; don't be "sold"!**

How to buy health insurance as an individual

- If you do want an agent to visit, ask him or her to make an appointment. Have a family member or friend with you. **Listen carefully. Take time to decide. Never purchase immediately.** Take time to talk to family and friends. Call SHINE for help in evaluating whether you actually need this extra insurance.
- Scare tactics are not permitted by Massachusetts insurance regulation. Most agents are honest and present accurate information. Only a small minority use inappropriate tactics. Report high pressure sales to the Division of insurance immediately.

If you do buy, remember that you have 10 to 30 days once you receive your policy to return it for full refund. Check your policy or ask your agent how many days you have for the *"free look"* period.

Complaints Against Insurance Companies or Managed Care Organizations?

Call the Massachusetts Division of Insurance at **1-617-521-7777** (TDD: 617-521-7490) whenever sales agent of company behavior appears to be incorrect. Also, you may send in your written complaint to: **Division of Insurance, 470 Atlantic Ave., Boston, MA 02210-2223.**

7. OTHER HEALTH BENEFITS PROGRAMS

Are there any other programs to help people in need of medical care?"
Yes, there are several other programs available if you have a low monthly income and limited assets.

Medicaid and Supplemental Security Income (SSI)
SSI is a cash benefit to help low-income seniors 65 years or older and the blind or disabled of any age. If you meet the income and asset requirements, the program pays a monthly check and guarantees automatic eligibility for Medicaid. To apply, call Social Security at 1-800-772-1213; or TDD: 1-800-325-0778.

Preventive Health Services Offered at Federally Qualified Health Centers
Another option that can help limit your health care costs is to receive health services at a Federally Qualified Health Center (FQHC). Medicare pays for additional health services at the FQHC that are not otherwise Medicare-covered services, such as preventive care services, including:

- routine physical examinations
- screening and diagnostic tests for the detection of vision and hearing problems
- administration of certain vaccines

You do not have to pay the $100 Medicare Part B deductible for services provided at a FQHC. While the Part B coinsurance applies to all FQHC services, guidelines allow FQHCs to waive it in some instances. Any Medicare beneficiary may seek services at a FQHC. To find out whether one of these centers serves your area, call 1-800-638-6833.

MassHealth Insurance Coverage for Disabled or Low-Income or Long Term Unemployed Adults and Families
This state program provides health care benefits to disabled working adults and disabled children, low income workers and long term unemployed individuals. For general information about MassHealth benefits call the MassHealth Customer Service Center at 1-800-841-2900. TDD: 1-800-497-4648.

Free Hospital Care or Partial Free Care
Hospitals are required to provide free hospital care or partial free care for services billed by the hospital. Call your local hospital's billing or customer service department to apply. For general information, you may contact the Department of Medical Security at 1-617-988-3138.

Senior Pharmacy Program

Individuals 65 and over whose income is below $11,844 (assets are not counted) may receive up to $750 in prescription medication through the Senior Pharmacy Program. Enrollment will be continuous, and applicants age 65 at the time of application will be eligible for the current benefit year. There is a $10 co-payment for brand name and $ for generic. To request an application call 1-800-953-3305. TDD: 617-926-5717.

Prescription Drug Assistance from Voluntary Drug Company Programs

More than 50 drug companies offer free prescription drugs to people of all ages who qualify. Each drug company has different guidelines. To obtain a list of the drugs that are covered and a sample application form, please call Mass Home Care's Elder Line at 1-800-243-4636. Your doctor can also explain the program.

For More Information or Help Applying For These Benefits and Programs

SHINE Health Insurance Counselors are trained and certified by the Executive Office of Elder Affairs to help you understand your options and help you apply to programs. If you have any questions about your current health care coverage, or the new public and private health insurance options available to residents of Massachusetts, please call your local SHINE Program today!

SHINE Regional Program Telephone List

Area # Number	SHINE Regional Program	SHINE Coordinator	Telephone Number
Western Mass:			
01	Berkshire County Program	Martha Seymour	800-957-3557
02	Franklin & Hampshire Counties Regional Program	Kristen Hershberger	800-498-4232
03	Hampden County/ Springfield	Gail Noe	800-307-4463
Central Mass:			
04	Worcester County/ Central Mass AAA	Kerri Sandberg	800-244-3032
05	BayPath / Framingham	Pam LeFrancois	800-287-7284
06	HESSCO/Foxboro	Peggy McDonough	800-462-5221
Northeastern Mass:			
07	North Shore Program / Danvers	Sara Bronstein	800-598-1122
08	Minuteman Home Care/ Cambridge & Somerville	Cynthia Phillips	781-272-7177
09	Merrimack Valley Elder Services Lawrence	Francesca Yeltin	800-892-0890
Eastern Mass:			
10	Mystic Valley Elder Services	Holly Kisler	781-324-7705
11	West Suburban/ Needham	Margaret McKay	617-964-5009
12	South Shore Area/Quincy	Jane Mudge	617-376-1247
13	City of Boston	Community Advocates	617-635-3995
Southeastern Mass:			
14	Martha's Vineyard	Beth Fletcher	800-334-9999
15	Plymouth County/ Middleborough COA	Andrea Priest	800-231-1155
16	Bristol County/ Attleboro	Lisa Sarkis	800-987-2510
17	Coastline Elder Services	Carolyn Avery	508-999-6400
18	Cape Cod Regional Program	Beth Fletcher	800-334-9999

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Medicare Telephone Numbers to Note

SHINE - Serving Health Information Needs of Elders Health Insurance Counseling Program 1-800-882-2003	Free and objective health insurance counseling program for Medicare beneficiaries and elders sponsored by the Mass. Executive Office of Elder Affairs.
Medicare Part B Carrier 1-800-882-1228	Medicare Part B claims and coverage questions (except DME).
Durable Medical Equipment (DME) Carrier 1-800-842-2052	Durable medical equipment claims and coverage questions.
Medicare Part A Intermediary 1-888-896-4997	Medicare Part A claims and coverage questions .
Mass Peer Review Organization 1-800-252-5533	Investigates complaints about poor quality of care received by a Medicare beneficiary from a Medicare HMO or any hospital, nursing facility or home health agency.
Health Care Financing Administration (HCFA) - Medicare Beneficiary Services 1-617-565-1232	Assistance for all Medicare issues.
MassHealth for Medicaid, QMB, and SLMB 1-800-841-2900	Eligibility, applications and coverage information.
Medicare Advocacy Project 1-800-323-3205	Provides free advice and free legal aid to Medicare beneficiaries.
Medicare Fraud and Abuse Hotline 1-800-447-8477	Investigates reports about Medicare fraud and abuse.
Social Security Administration 1-800-772-1213	Medicare enrollment, and issues new Medicare cards.
Senior Pharmacy Program 1-800-953-3305	Helps seniors with incomes up to $12,084/year to buy medicine.

Serving Health Information Needs of Elders
c/o Massachusetts Executive Office of Elder Affairs
1 Ashburton Place, 5th floor